

Crouse Community Center
101 South Street
Morrisville, NY 13408

APPLICATION FOR ADMISSION - MEDICAL

(Note: To Be Completed By Physician)

Name of Applicant: _____ Date of Birth: _____

Address: _____

Sex: _____

Active Diagnoses: _____

Medications	Dose	Route	Frequency	Reason For Use

Past Medical History: _____

Past Surgical Procedures / Dates: _____

Recent Lab Work: _____

Recent X-Rays: _____

Allergies: _____

Pneumovax: Yes / No Date: _____ Flu Vaccine: Yes / No Date: _____
TB Skin Test: Yes / No Date: _____ Result: _____

Tetanus Immune Status: _____

Current Treatments: _____

Name of Applicant: _____

~~Application for Admission-Medical Continued~~

Pressure Ulcers: Yes / No State & Location: _____

Other Skin Conditions: _____

History of Alcoholism: _____

History of Drug Addiction: _____

History of OR Current Communicable Disease: _____

Advanced Directives: _____ DNR _____ Health Care Proxy _____ Power of Attorney _____ Living Will

List Specialists Seen By Applicant: _____

Dentist: _____ Podiatrist: _____

Audiologist: _____ Ophthalmologist: _____

Psychiatrist: _____ Other: _____

Special Diet or Consistency: Yes / No Specify: _____ Feeds Self: Yes / No

Hearing: WNL / Impaired / Severe Hearing Aid: Yes / No

Vision: WNL / Impaired / Severe Glasses: Yes / No

Speech: WNL / Impaired / Severe

Mental Status: (Check All That Apply) _____ Oriented _____ Cooperative _____ Wanders

Confusion: _____ Occasionally _____ Always _____ Noisy _____ Assaultive _____ Agitated

Other: _____

Dementia Screen Done: Yes / No

History of Psychiatric Problems / Current Status: _____

Mobility: _____ Ambulatory _____ With / Without Assist

Devices Used: _____ Cane _____ Walker _____ W/C _____ Other _____

Incontinence: Bladder: _____ Always _____ Occasionally _____ At Night

Bowels: _____ Always _____ Occasionally _____ At Night

Continent: _____ Foley Catheter / Size / Reason: _____

Colostomy: _____

Recommendations for Routine Care: _____

Do You Recommend Nursing Facility Placement? Yes / No

Physician's Signature: _____ Date: _____

Physician's Address: _____

Note: Please Include Copies of Most Recent History and Physical, Any Recent Lab Work and Any Operative Reports.... Without the Above Information Admission May be Denied

State and Federal Laws Prohibit Discrimination Based on Race, Creed, Color, National Origin, Sex or Sponsor
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